Appointment Cancellation Policy Agreement

Vermont Physical Therapy is committed to providing all of our patients with exceptional care. When a patient cancels without giving enough notice, they prevent another patient from being seen.

Please call us at least 24 hours in advance of your scheduled appointment to notify us of any changes or cancellations. **To cancel a *Monday* appointment**, **please call our office on Friday.**

If proper notification is not given, our office reserves the right to charge a $40 missed appointment fee.

Please call the office at (802) 497-0736 with any scheduling concerns.

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Reminder messages will be sent via phone call, text, or email. This is a courtesy only. It is the patient's responsibility to keep scheduled appointments regardless of whether the patient received a reminder.

Please sign below to acknowledge these terms.

PRINTED NAME _____ **DATE** _____

SIGNATURE _____ **DATE** _____
(Patient's Parent/Guardian if under 18)

CONSENT TO TREAT

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended physical, medical or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s).

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership. The consent will remain fully effective until it is revoked in writing. You have the right at any time to discontinue services.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks, and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommended by your health care provider, we encourage you to ask questions.

I voluntarily request a mid level provider (Physical Therapist), or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition, which has brought me to seek care at this practice. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

PRINTED NAME _____ **DATE**_____

SIGNATURE_____

(Patient's Parent/Guardian if under 18)

OFFICE POLICIES

Please read this form in its entirety and sign at the bottom to indicate your acknowledgment.

The staff and management of Vermont Physical Therapy promise to:

- Provide a caring and professional environment where you will receive the best care at all times.
- Provide you with an individually designed treatment plan to meet your specific needs and goals.
- Answer any questions you may have.
- Do our best to respect your time by staying on schedule, as well as respecting your privacy and dignity during treatment sessions.
- Request authorization for services rendered, when required, in a timely manner.
- Provide you with clearly defined payment options in order to insure continued access to quality treatment.

We appreciate your commitment to:

- Being an active participant in your physical therapy treatment by arriving on time for appointments, informing your clinician of any concerns or questions you may have, complying with home exercise instructions or other recommendations.
- Giving proper notice for all cancellations. Please call us 24 hours before your scheduled appointment to notify us of changes or cancellations. To cancel a Monday appointment, please call our office on Friday. If proper notification is not given, you will be charged $40.00 for the missed appointment.
- Paying co-payments at the time of service. Patients without insurance are asked to pay in full at the time of each appointment. We accept most major credit cards, personal checks, and cash.
- Knowing the provisions and limitations of your insurance coverage; and understanding that your policy is a contract between you and your insurance carrier. We recommend you to call your insurance company to become familiar with your plan.
- Understanding your treatment plan is based on medical necessity (as determined by your referring physician or treating physical therapist) and is not based on the limitations of your insurance policy.
- Request alternate treatment or payment arrangements if necessary.
- Understanding that balances over 90 days past due will be referred to our collections agency.

PRINTED NAME _____ **DATE** _____

SIGNATURE _____ **DATE** _____
(Patient's Parent/Guardian if under 18)

Your feedback is important to us; whether it is praise or constructive criticism, let us know what you think. Help our practice thrive by recommending Vermont Physical Therapy to your friends, family, and healthcare providers.

NOTICE OF PRIVACY POLICY FOR PROTECTED HEALTH

TO OUR PATIENTS

This notice describes how health information about you as a patient to this practice may be used and disclosed, and how you can get access to your health information. This is required by the Privacy Regulations created as a result of the Health Insurance Portability Act (HIPAA) of 1996.

OUR COMMITMENT TO YOUR PRIVACY

Our practice is dedicated to maintaining the privacy of your health information. We are required by law to maintain the confidentiality of your health information.

HOW WE COLLECT YOUR INFORMATION

Your personal demographic information such as name, address, birth date, social security number, and medical insurance information is obtained by you. This is why we ask you to fill out the patient information sheet and why we ask for a copy of your insurance card. This insures you that the information we collect is correct. We may ask a doctor or other health care provider who referred you to this practice to give us health information that will enable us to better treat your medical condition. This benefits you in that we will have test results that have already been obtained by the referring entity.

WHY WE COLLECT THIS INFORMATION

We collect this information so that we can treat your condition and obtain payment from you or your health insurance.

MAINTAINING ACCURATE AND TIMELY INFORMATION

To insure that the information we maintain is accurate, each time you visit this office you will be asked if any of your information needs to be updated.

WHO HAS ACCESS TO THIS INFORMATION

Any person or persons you designate in writing, people directly involved in your medical care, people creating and maintaining your medical record, and those entities that need your information to process health care claims and obtain payment for our services have access to your Protected Health Information.

Entities such as Government Oversight Agencies, Judicial and Administrative Proceedings, Law Enforcement Agencies, Coroners and Medical Examiners, and Organ Procurement Organizations may obtain copies of your Protected Health Information. These entities are mandated by law and this practice has no jurisdiction over such entities.

HOW WE PROTECT YOUR INFORMATION

We release your information only to those people who need your information. We maintain physical, electronic, and procedural safeguards so that no one but persons involved in your health care or entities that need this information for claims processing have access to your Protected Health Information.

YOUR RIGHTS

You have the right to request that our practice communicate with you about your health and related issues in a particular manner or at a certain location. You have the right to request a restriction on the use or disclosure of your health information except as provided by law.

You have the right to inspect and obtain a copy of the health information that may be used to make decisions about you, including patient medical records and billing records, but not including psychotherapy notes. Your request must be in writing to our office.

You have the right to ask us to amend your health information if you believe it is incorrect or incomplete. This request must be in writing and state a reason that supports your request for amendment.

If you leave this practice your Protected Health Information will continue to receive the protection outlined in this notice.

If you believe your privacy rights have been violated you may file a complaint with our practice or with the Secretary of the Department of Health and Human Services. All complaints must be in writing. You will not be penalized for filing a complaint.

This practice reserves the right to amend our privacy policy as dictated by law without sending you a copy of the amendment. Any changes to this policy will be posted in our office. This notice is effective as of April 14, 2003.

PRINTED NAME _____ **DATE** _____

SIGNATURE _____ **DATE** _____

(Patient's Parent/Guardian if under 18)

MEDICAL HISTORY

Do you have or have you experienced any of the following?

High blood pressure	Y	N	Cancer	Y	N
Heart disease	Y	N	Osteoporosis	Y	N
Chest pain	Y	N	Severe headaches	Y	N
Shortness of breath	Y	N	Fractures	Y	N
Lung disease	Y	N	Thyroid condition	Y	N
Recent weight loss/gain	Y	N	Joint pain or swelling	Y	N
Heartburn	Y	N	Latex sensitivity	Y	N
Diabetes	Y	N	Recent/Prolonged fever	Y	N
Low blood sugar	Y	N	Alcoholism	Y	N
Urinary incontinence	Y	N	Blood disorder	Y	N
Impaired, uncorrected vision	Y	N	Impaired hearing	Y	N
HIV positive	Y	N	Psychological Disorder _____		
Neurological disorder	Y	N	Other _____		

Height _____ ***REQUIRED***
Weight _____ ***REQUIRED***

Please list all medications you are currently taking below or provide us with a separate list.

Medication	Dosage	Reason
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list any known allergies.

_____

Please list all surgeries you have had and their approximate dates.

_____

Please list all diagnostic tests you have had for your current injury or condition.

_____

Please list any physical therapists or chiropractors you have been treated by in the past.

_____

OB/GYN History

Currently pregnant	Y	N	Abnormal menstrual cycles	Y	N
Complicated pregnancies	Y	N	Pelvic inflammatory disease	Y	N
Post-menopausal	Y	N	6+ months post-partum/post-weaning	Y	N

The purpose of this questionnaire is to assist us in providing you quality care by obtaining a better understanding of your total status. Your physical therapist will answer any questions during your initial visit. We appreciate your completion of this questionnaire and will keep this as part of your confidential medical record.

PRINTED NAME _____ **DATE** _____

SIGNATURE _____ **DATE** _____
(Patient's Parent/Guardian if under 18)